Disclosure of Financial Policies

PATIENTS: PLEASE KEEP THIS PAGE FOR YOUR RECORDS

FINANCIAL POLICY: The Physical/Occupational Therapists and staff of Select Therapy are pleased to welcome you to our practice. Select Therapy firmly believes that a positive patient experience is based upon good understanding and communication of all aspects of your physical therapy care. These financial policies have been developed in an effort to remove any misunderstanding that may arise regarding your account. These policies are also designed in an effort to enable us to continue providing quality, state-of-the-art patient care in a cost-effective manner.

If you have any questions or do not understand any of these policies, please feel free to ask any of our managers.

REGISTRATION: Upon your initial visit, our front desk staff will collect your billing/insurance information as well as your address, telephone number, birth date, employer information, emergency contact information, and other pertinent information. It is extremely important that this information is kept up to date.

PAYMENT FOR SERVICES: Payment for services provided to you is ultimately your responsibility. If you have health insurance, we will gladly file a claim with your health insurance company. If your injury is a result of a work injury, motor vehicle accident, or personal injury, we will file your claim to the appropriate insurance company on your behalf. We accept cash, personal checks, Visa, MasterCard, and Discover to cover any remaining balance (co-payments, co-insurance, deductibles, etc). If your insurance has a co-payment, we will collect that amount at each visit. For your convenience, we can automatically apply your co-payment to a credit/debit card of your choice.

ACCEPTANCE OF AUTO/WORKER'S COMPENSATION/PERSONAL INJURY PATIENTS: We accept patients with the understanding that a "good faith" effort must be made by the patient to participate in scheduled sessions as well as comply with the financial responsibilities of care. Ultimately, it is the patient's responsibility for the cost of care if claims are denied.

SELF-PAY PLAN: If you are self-pay, you will be expected to make mutually agreeable payment arrangements prior to receiving physical therapy treatment. You will be billed for these items directly. A "Self Payment" form must be signed prior to receiving physical therapy care.

BILLING STATEMENTS: We have designed our billing statements to reflect the individual charges billed, the payments and adjustments related to those charges, and the balance due. These statements will also reflect an amount due from you, as well as a balance due from your insurance company. Patients with a personal balance will receive a monthly statement showing the specific amounts due. These statements are due upon receipt. Because the posting of payments can sometimes be posted days following the day of payment, you may receive a statement that does not reflect a payment that was made on the day of service or sent by your insurance company. If you receive subsequent statements, which do not reflect the payment, please contact our office to investigate.

PAST DUE ACCOUNTS: Past-due accounts cost both time and money; therefore, patients with delinquent accounts will be required to make payment at the time of service. If you are unable to make mutually agreeable payment arrangements, we will be glad to reschedule your appointment. Interest will be charged at an annual rate of 18% on all past due patient balances.

PAST DUE 90+: Those accounts older than 90 days or those failing to honor agreed-upon payment terms will be sent to a collection agency. If your account is sent to a collection agency, you must pay all past due amounts or make agreeable payment terms before subsequent appointments can be scheduled. Additionally, patients can be dismissed from our practice for financial matters and will have to seek their health care elsewhere. You will be responsible to pay all costs associated with collection efforts to include attorney's fees and court costs and filing fees.

BILLING QUESTIONS: Questions or concerns regarding your account or insurance claim should be directed our Billing Department. Please notify us immediately if you feel an error appears on your statement or if you have any questions or concerns.

PATIENT SERVICES HOTLINE: 218-824-5027

FAILED APPOINTMENTS: We understand there may be unforeseen circumstances in which you may be unable to make your scheduled appointment. If this occurs, please contact our facility as soon as you can so we may reschedule, and to make the time available for another patient. Canceling an appointment with little notice or failing to attend takes up clinic time that would be beneficial to other patients. In an effort to enforce this policy, you will be charged $25 if you cancel an appointment less than 24 hours before your appointment time, or if you fail to show. Management may waive this fee on an exception basis. Canceling or "no showing" for more than three appointments may result in same day scheduling, restricting your ability to schedule appointments in advance from that point forward.

Your progress to recovery is very important to us and your commitment is a very important part of this. If you know you are going to have a difficult time making your appointments, please discuss this with your therapist. We will do our best to accommodate your needs.

Baxter
14884 Kirkwood Drive
Baxter, MN 56425
P: 218.824.5027
F: 218.824.8011

Crosslake
35544 Sandpoint Drive Suite A
Crosslake, MN 56442
P: 218.692.5020
F: 218.692.5021

Pierz
26814 143rd Street
Pierz, MN 56364
P: 320.468.0183
F: 320.468.2075

Inver Grove Heights
5836 Blaine Avenue
Suite 105
IGH, MN 55076
P: 651.455.0535
F: 651.455.1565

Pine River
409 Barclay Avenue
PO BOX 785
Pine River, MN 56474
P: 218.587.5022
F: 855.367.2851

Takedown Gym
17192 State Hwy 371
Brainerd, MN 56401
P: 218.824.5027
F: 218.821.8011

Pequot Lakes
31009 Front Street
Pequot Lakes, MN 56401
P: 218.824.5027
F: 218.821.8011

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Patient's Name: _____ **Date of Birth:** _____

Guarantor/Responsible Party's Name (if different than patient): _____

PATIENT AUTHORIZATION I hereby consent to physical/occupational therapy treatment by Select Therapy and further assign all medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers including auto insurance, worker's compensation insurance, and personal injury insurance to Select Therapy and also authorize the release of any medical records necessary to process medical claims. If worker's compensation insurance, auto insurance, or personal injury insurance denies my claim, or part of my claim, I authorize Select Therapy to bill my private health insurance. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. If my claim is denied by worker's compensation insurance, auto insurance, personal injury insurance, and/or my private health insurance and I fail to obtain a Letter of Protection or Doctor's Lien from an attorney, I will be financially responsible for payment. I also understand that in the event my account becomes 30 days past due, finance charges will be applied to my outstanding balance at the rate of 1.5% per month (18% per year). If my account goes to collections, I will be financially responsible for all debt collections fees to include attorney's fees and court costs and filing fees.

I acknowledge with my signature that I have received, read, reviewed, and understand Select Therapy's Disclosure of Financial Policies and authorize Select Therapy to hold me accountable to its entire contents. I have been given the opportunity to consult with legal council concerning this binding contract.

_____ _____

Signature of Patient/Guardian/Responsible Party Date

HIPAA By signing below, I am acknowledging that Select Therapy, Inc presented to me a copy of the HIPAA Privacy Act on this date. Please see clipboard and/or ask for a copy to take home.

_____ _____

Signature of Patient/Guardian/Responsible Party Date

Cancellation/No Show Fee By signing below, I am acknowledging that Select Therapy, Inc presented me a copy of their Cancellation/No Show Policy on this date. If I choose not to abide by this policy, I consent to pay a $25 penalty charge.

_____ _____

Signature of Patient/Guardian/Responsible Party Date

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